DISTRICT OF COLUMBIA GOVERNMENT
DEPARTMENT OF HEALTH CARE FINANCE

To: **Social Security Administration** **Date:** _____

Washington, D.C. _____
Attn: SSI Unit

From: **Department of Health Care Finance**
Central Referral Bureau
825 North Capitol St. NE
Washington, DC 20002

Subject: Adult Foster Care Homes (Community Residential Facility or Assisted Living Facility): Authorization/Certification Or Termination/Decertification

Applicant: _____ _____
Representative Payee, Contact #

SSN: _____

Current Applicant
Address and Contact #: _____

☐ **(OS-A). This certifies that the individual identified above resides in an Adult Foster Care Home (CRF or ALF) with a capacity of fifty (50) or fewer residents and is entitled to an Optional State Supplement effective_____.**

☐ **(OS-B). This certifies that the individual identified above resides in an Adult Foster Care Home (CRF or ALF) with a capacity of fifty (50) or more residents and is entitled to an Optional State Supplement effective_____.**

☐ **This certifies that the individual identified above is no longer residing in an Adult Foster Care Home (CRF or ALF) and is not eligible for and Optional State Supplement. Terminate effective_____.**

_____ _____
Signature, Title of Initiating Official, Date **Signature of CRB Official**

_____ _____
Agency and Contact # **Title of CRB Official, Date**

Remarks:_____
_____

SSA instructions for processing this form can be found in POMS SI PHI01415.009

Rev. Department of Health Care Finance **June 2009**